Exhibit E
Additional Provisions

Attachment 3

Duties of the State

In discharging its obligations under this Contract, the State will perform the following duties:

1. Payment For Services

Pay the appropriate capitation payments set forth in Exhibit B. Payment Provisions, to the Contractor for each eligible Member under this Contract, and ensure that such payments are reasonable and do not exceed the amount set forth in 42 CFR, Section 447.361. Payments will be made monthly for the duration of this Contract. Any adjustments for federally qualified health centers will be made in accordance with Section 14087.325 of the Welfare and Institutions Code.

2. Medical Reviews

Conduct medical reviews in accordance with the provisions of Section 14456, Welfare and Institutions Code. DHS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies which use standards comparable to those of DHS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHS in order to eliminate duplication of auditing efforts.

3. Enrollment Processing

A. General

The parties to this Contract agree that the primary purpose of DHS' Medi-Cal managed care system is to improve quality and access to care for Medi-Cal beneficiaries. The parties acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. The parties also acknowledge that it is impractical to ensure that every beneficiary eligible for enrollment in the Contractor's plan will be enrolled in a timely manner. Furthermore, the parties recognize that for a variety of reasons some Eligible Beneficiaries will not be enrolled in Contractor's plan and will receive Covered Services in the Medi-Cal fee-for-service system. These reasons include, but are not limited to, the exclusion of some beneficiaries from participating in Medi-Cal managed care, the time it takes to enroll beneficiaries, and the lack of a current valid address for some beneficiaries. The parties desire to work together in a cooperative manner so that Eligible Beneficiaries who choose to or should be assigned to Contractor's plan are enrolled in Contractor's plan pursuant to the requirements of this entire provision 3. The parties agree that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

B. Definitions

For purposes of this entire provision 3. Enrollment Processing, the following definitions shall apply:

1) Fully Converted County means a county in which the following circumstances exist, except for those Medi-Cal beneficiaries covered by Title 22, CCR, Section 53887:

a. Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) may no longer choose to receive Covered Services on a Fee-for-Service basis; and

b. All new Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) must now choose a managed care plan or they will be assigned to a managed care plan; and

c. All Eligible Beneficiaries listed in MEDS as meeting the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) on the last date that both a. and b. above occur:

- have been notified of the requirement to choose a managed care plan and informed that if they fail to choose a plan they will be assigned to a managed care plan; and

- those beneficiaries still eligible for Medi-Cal and enrollment into a managed care plan at the time their plan enrollment is processed in MEDS have been enrolled into a managed care plan.

2) Mandatory Plan Beneficiary means:

a. A new Eligible Beneficiary who meets the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a), both at the time her/his plan enrollment is processed by the DHS Enrollment Contractor and by MEDS; or

b. An Eligible Beneficiary previously receiving Covered Services in a county without mandatory managed care enrollment who now resides in a county where mandatory enrollment is in effect and who meets the mandatory

enrollment criteria contained in Title 22, CCR, Section 53845(a); or

c. An Eligible Beneficiary meeting the criteria of Title 22, CCR, Section 53845(b), and who subsequently meets the criteria of Title 22, CCR, Section 53845(a).

3) Mandatory Plan Beneficiary shall not include any Eligible Beneficiary who:

a. is eligible to receive Covered Services on a Fee-for-Service basis because her/his MEDS eligibility for managed care plan enrollment is interrupted due to aid code, ZIP code or county code changes; or

b. becomes eligible for enrollment in a managed care plan on a retroactive basis.

C. DHS Enrollment Obligations

1) DHS shall receive applications for enrollment from its enrollment contractor and shall verify the current eligibility of applicants for enrollment in Contractor's plan under this Contract. If the Contractor has the capacity to accept new enrollees, DHS or its enrollment contractor shall enroll or assign eligible applicants in Contractor's plan when selected by the applicant or when the applicant fails to timely select a plan. Of those to be enrolled or assigned in Contractor's plan, DHS will ensure that in a Fully Converted County a Mandatory Plan Beneficiary will receive an effective date of plan enrollment that is no later than 90 days from the date that MEDS lists such an individual as meeting the enrollment criteria contained in Title 22, CCR, Section 53845(a), if all changes to MEDS have been made to allow for the enrollment of the individual and all changes necessary to this Contract to accommodate such enrollment, including, but not limited to rate changes and aid code changes, have been executed. DHS will use due diligence in making any changes to MEDS and to this Contract. DHS will provide Contractor a list of Members on a monthly basis.

2) DHS or its enrollment contractor shall assign Eligible Beneficiaries meeting the enrollment criteria contained in Title 22, CCR, Section 53845(a) to plans in accordance with Title 22, CCR, Section 53884.

3) Notwithstanding any other provision in this Contract, subparagraphs 1) and 2) above shall not apply to:

a. Eligible Beneficiaries previously eligible to receive Medi-Cal services from a Prepaid Health Plan or Primary Care Case Management plan and such plan's contract with DHS expires, terminates, or is assigned or transferred to Contractor;

b. Members who are enrolled into another managed care plan on account of assignment, assumption, termination, or expiration of this Contract;

c. Eligible Beneficiaries covered by a new mandatory aid code, added to this Contract;

d. Eligible Beneficiaries meeting the criteria of Title 22, CCR, Section 53845(b), who subsequently meet the criteria of Title 22, CCR, Section 53845(a) due solely to DHS designating a prior voluntary aid code as a new mandatory aid code;

e. Eligible Beneficiaries residing in an excluded zip code area within a County that is not a fully Converted County; or

f. Eligible Beneficiaries without a current valid deliverable address or with an address designated as a County post office box for homeless beneficiaries.

D. Disputes Concerning DHS Enrollment Obligations

1) Contractor shall notify DHS of DHS' noncompliance with this provision 3. Enrollment Processing pursuant to the requirements and procedures contained in Exhibit E, Attachment 2, provision 18. Disputes.

2) DHS shall have 120 days from the date of DHS' receipt of Contractor's notice (the "cure period") to cure any noncompliance with this provision 3. Enrollment Processing, identified in Contractor's notice, without incurring any financial liability to the Contractor. For purposes of this section, DHS shall be deemed to have cured any noncompliance with this provision 3. Enrollment Processing, identified in Contractor's notice if within the cure period any of the following occurs:

a. Mandatory Plan Beneficiaries receive an effective date of plan enrollment that is within the cure period, or

b. DHS corrects enrollment that failed to comply with this provision 3. Enrollment Processing, by redirecting enrollment from one Contractor to another within the cure period in order to comply with this provision 3. Enrollment Processing, or

c. Within the cure period, DHS changes the distribution of beneficiary Assignment (subject to the requirements of Title 22, CCR, Section 53845(b)(1) through (b)(4)), to the maximum extent new beneficiaries are available to be assigned, to make up the number of incorrectly assigned beneficiaries as soon as possible.

3) If it is necessary to redirect enrollment or change the distribution of beneficiary Assignment due to noncompliance with this provision 3. Enrollment Processing, and such change varies from the requirements of Title 22, CCR, Section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHS resumes assignment consistent with Sections 53884(b)(5) or (b)(6) after correcting a noncompliance with this provision 3. Enrollment Processing.

4) Notwithstanding Exhibit E, Attachment 2, provision 1. Governing Law or any other provision of this Contract, if DHS fails to cure a noncompliance with this provision 3. Enrollment Processing, within the cure period, DHS will be financially liable for such noncompliance as follows:

DHS will be financially liable for Contractor's demonstrated actual reasonable losses as a result of the noncompliance, beginning with DHS' first failure to comply with its enrollment obligation set forth herein. DHS' financial liability shall not exceed 15 percent of Contractor's monthly capitation payment calculated as if noncompliance with this provision 3. Enrollment Processing did not occur, for each month in which DHS has not cured noncompliance pursuant to paragraph D. subparagraph 2) above, beginning with DHS' first failure to comply with its enrollment obligation set forth herein.

5) Notwithstanding paragraph D. subparagraph 4) above, DHS shall not be financially liable to Contractor for any noncompliance with provision 3. Enrollment Processing, in an affected county (on a county-by-county basis) if Contractor's loss of Mandatory Plan Beneficiaries, in a month in which any noncompliance occurs, is less than five percent of Contractor's total Members in that affected county in the month in which the noncompliance occurs.

The parties acknowledge that the above-referenced five-percent threshold shall apply on a county-by-county basis, not in the aggregate.

4. Disenrollment Processing

Review and process requests for Disenrollment and notify the Contractor and the Member of its decision.

5. Approval Process

A. Within five (5) State working days of receipt, DHS shall acknowledge in writing the receipt of any material sent to DHS by Contractor pursuant to Exhibit E, Attachment 2, provision 8. Obtaining DHS Approval.

B. Within sixty (60) days of receipt, DHS shall make all reasonable efforts to approve in writing the use of such material provided to DHS pursuant to Exhibit E, Attachment 2, provision 8. Obtaining DHS Approval, provide Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHS' review process. If DHS does not complete its review of submitted material within sixty (60) days of receipt, or within the estimated date of completion of DHS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHS. This paragraph shall not be construed to imply DHS approval of any material that has not received written DHS approval. This paragraph shall not apply to Subcontracts or sub-subcontracts subject to DHS approval in accordance with Exhibit A, Attachment 6, provision 13. Subcontracts, paragraph C. regarding Departmental Approval – Non-Federally Qualified HMOs, and paragraph D. regarding Departmental Approval – Federally Qualified HMOs.

6. Program Information

Provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within thirty (30) days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, DHS shall notify Contractor within thirty (30) days, in writing, of the reason for the delay and when Contractor may expect the information.

7. Catastrophic Coverage Limitation

Limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to, Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

8. Risk Limitation

Terminate the Contractor's financial liability to provide Covered Services to a Member on a risk basis in those situations where, during **the 12 month period beginning _____and ending _____, or any succeeding 12 month period commencing _____, and ending the following _____,** the Member has received Medically Necessary Covered Services, as determined by DHS, from the Contractor in an amount in excess of $_____, based upon Medi-Cal schedules of reimbursement, and exclusive of payments recovered by Contractor from third-party payors. Affected Members will not be disenrolled because of their need of services in excess of $_____, and the Contractor will be responsible to provide or arrange and pay for, Medically Necessary Covered Services for such Members. Contractor will be reimbursed for such continuing care in excess of $_____ by DHS, based on Medi-Cal schedule of reimbursement or the Contractor's costs, whichever is lower, and exclusive of payments recovered by the Contractor from third-party payors, as determined by DHS upon Contractor submission to DHS of appropriately documented claims for such services provided during the 12-month period specified above.

The dates set forth in this paragraph only serve to establish the beginning and ending dates of the risk limitation period and will not be construed to extend the Contractor's responsibility to render services under this Contract nor DHS' responsibility to pay for services rendered beyond the date on which this Contract terminates. The establishment of a risk limitation period that extends beyond the term of the current Contract contemplates the possibility of (but does not bind the parties to) extension of the Contract. In the event the Contract is terminated or not extended, the risk limitation period will terminate upon termination of the Contract.

9. Notice Of Termination Of Contract

Notify Members of their health care benefits and options available upon termination or expiration of this Contract.